		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. **IDPH Facility ID Number:** 0042283

Facility Name: ASTA CARE CENTER OF BLOOMINGTON

Address: 1509 NORTH CALHOUN STREET (Number) BLOOMINGTON (City) 61701 (Zip Code)

County: MCLEAN

Telephone Number: (309) 827-6046 **Fax #** (309) 829-1992

IDPA ID Number: 36-1357503

Date of Initial License for Current Owners: 09/01/96

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[X]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. **CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) MICHAEL GILLMAN

(Title) PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)

(Print Name and Title) BOB KAGDA, PARTNER

(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124

(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	117	Skilled (SNF)	117	42,705	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	117	TOTALS	117	42,705	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	756	406	2,675	3,837	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	24,448	4,107	163	28,718	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,204	4,513	2,838	32,555	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.23%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 9/01/96

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 09/01/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 24 and days of care provided 2,173

Medicare Intermediary ADINISTAR OF KENTUCKY

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTO # 0042283 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	205,795	15,371	11,673	232,839		232,839	0	232,839			1
2	Food Purchase		123,546		123,546		123,546	(3,797)	119,749			2
3	Housekeeping	152,351	26,817	0	179,168		179,168	0	179,168			3
4	Laundry	50,433	4,942	8,823	64,198		64,198	0	64,198			4
5	Heat and Other Utilities			142,833	142,833		142,833	0	142,833			5
6	Maintenance	75,360	26,778	48,362	150,500		150,500	(4,298)	146,202			6
7	Other (specify):*			29,243	29,243		29,243	0	29,243			7
8	TOTAL General Services	483,939	197,454	240,934	922,327	0	922,327	(8,095)	914,232			8
	B. Health Care and Programs											
9	Medical Director	0		6,000	6,000		6,000	0	6,000			9
10	Nursing and Medical Records	940,240	60,116	192,132	1,192,488		1,192,488	0	1,192,488			10
10a	Therapy	88,399		0	88,399		88,399	0	88,399			10a
11	Activities	51,840	7,524	1,536	60,900		60,900	0	60,900			11
12	Social Services	41,748		0	41,748		41,748	0	41,748			12
13	Nurse Aide Training			0	0		0	0	0			13
14	Program Transportation			0	0		0	0	0			14
15	Other (specify):*				0		0	0	0			15
16	TOTAL Health Care and Programs	1,122,227	67,640	199,668	1,389,535	0	1,389,535	0	1,389,535			16
	C. General Administration											
17	Administrative	101,592		132,500	234,092		234,092	(100,949)	133,143			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			42,292	42,292		42,292	617	42,909			19
20	Dues, Fees, Subscriptions & Promotions			79,142	79,142		79,142	(55,708)	23,434			20
21	Clerical & General Office Expenses	97,044	28,837	42,308	168,189		168,189	65,056	233,245			21
22	Employee Benefits & Payroll Taxes			260,320	260,320		260,320	0	260,320			22
23	Inservice Training & Education			5,875	5,875		5,875	0	5,875			23
24	Travel and Seminar			181	181		181	63	244			24
25	Other Admin. Staff Transportation			6,181	6,181		6,181	3,281	9,462			25
26	Insurance-Prop.Liab.Malpractice			50,081	50,081		50,081	3,330	53,411			26
27	Other (specify):*			14,574	14,574		14,574	(4,657)	9,917			27
28	TOTAL General Administration	198,636	28,837	633,454	860,927	0	860,927	(88,967)	771,960			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,804,802	293,931	1,074,056	3,172,789	0	3,172,789	(97,062)	3,075,727			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON #0042283 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			29,636	29,636		29,636	(3,587)	26,049			30
31	Amortization of Pre-Op. & Org.			262	262		262	0	262			31
32	Interest			29,005	29,005		29,005	14	29,019			32
33	Real Estate Taxes			37,717	37,717		37,717	0	37,717			33
34	Rent-Facility & Grounds			512,551	512,551		512,551	0	512,551			34
35	Rent-Equipment & Vehicles			10,415	10,415		10,415	855	11,270			35
36	Other (specify):*				0		0	0	0			36
37	**TOTAL Ownership**			619,586	619,586	0	619,586	(2,718)	616,868			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers			302,000	302,000		302,000	0	302,000			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			64,057	64,057		64,057	0	64,057			42
43	Other (specify):*				0		0	0	0			43
44	**TOTAL Special Cost Centers**	0	0	366,057	366,057	0	366,057	0	366,057			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,804,802	293,931	2,059,699	4,158,432	0	4,158,432	(99,780)	4,058,652			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(7,840)	30		9
10	Interest and Other Investment Income	(12)	32		10
11	Discounts, Allowances, Rebates & Refunds	(2,015)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,782)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(2,107)	25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(8,515)	21		18
19	Entertainment	0	20		19
20	Contributions	(5,846)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(4,567)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(14,574)	27		24
25	Fund Raising, Advertising and Promotional	(50,183)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule SEE PAGE 5A	(4,298)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (101,739)		$ 0	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	1,959		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 1,959		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (99,780)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

ASTA CARE CENTER OF BLOOMINGTON

ID# 0042283

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ -4298	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(4,298)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON **#** 0042283 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,797)	0	0	0	0	0	0	0	0	0	0	(3,797)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(4,298)	0	0	0	0	0	0	0	0	0	0	(4,298)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(8,095)	0	0	0	0	0	0	0	0	0	0	(8,095)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(100,949)	0	0	0	0	0	0	0	0	0	(100,949)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(4,567)	5,184	0	0	0	0	0	0	0	0	0	617	19
20	Fees, Subscriptions & Promotions	(56,029)	321	0	0	0	0	0	0	0	0	0	(55,708)	20
21	Clerical & General Office Expenses	(8,515)	73,571	0	0	0	0	0	0	0	0	0	65,056	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	63	0	0	0	0	0	0	0	0	0	63	24
25	Other Admin. Staff Transportation	(2,107)	5,388	0	0	0	0	0	0	0	0	0	3,281	25
26	Insurance-Prop.Liab.Malpractice	0	3,330	0	0	0	0	0	0	0	0	0	3,330	26
27	Other (specify):*	(14,574)	9,917	0	0	0	0	0	0	0	0	0	(4,657)	27
28	**TOTAL General Administration**	(85,792)	(3,175)	0	0	0	0	0	0	0	0	0	(88,967)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(93,887)	(3,175)	0	0	0	0	0	0	0	0	0	(97,062)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(7,840)	4,253	0	0	0	0	0	0	0	0	0	(3,587)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(12)	26	0	0	0	0	0	0	0	0	0	14	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	855	0	0	0	0	0	0	0	0	0	855	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(7,852)	5,134	0	0	0	0	0	0	0	0	0	(2,718)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(101,739)	1,959	0	0	0	0	0	0	0	0	0	(99,780)	45

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
LIST ATTACHED		LIST ATTACHED		SEE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 132,500	ASTA HEALTHCARE COMPANY		$	$ (132,500)	1
2	V								2
3	V	17	OFFICER SALARIES				31,551	31,551	3
4	V	19	PROFESSIONAL FEES				5,184	5,184	4
5	V	20	DUES, FEES,SUBSCRIPTIONS				321	321	5
6	V	21	OFFICE EXPENSES				73,571	73,571	6
7	V	27	EMPLOYEE BENEFITS				9,917	9,917	7
8	V	24	EDUCATION & SEMINARS				63	63	8
9	V	25	TRANSPORTATION STAFF				5,388	5,388	9
10	V	26	GENERAL INSURANCE				3,330	3,330	10
11	V	30	DEPRECIATION				4,253	4,253	11
12	V	32	INTEREST EXPENSE				26	26	12
13	V	35	EQUIPMENT RENT				855	855	13
14	Total			$ 132,500			$ 134,459	$ * 1,959	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTC # 0042283 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5		SEE ATTACHED									5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ASTA HEALTHCARE
Street Address: 134 N. MCLEAN
City / State / Zip Code: ELGIN, IL 60123
Phone Number: (847) 742-8822
Fax Number: (847) 742-9013

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	OFFICER SALARIES	PATIENT DAYS	154,774	5	$ 150,000	$ 150,000	32,555	$ 31,551	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	154,774	5	24,648		32,555	5,184	2
3	20	DUES, FEES,SUBSCRIPTIONS	PATIENT DAYS	154,774	5	1,525		32,555	321	3
4	21	OFFICE EXPENSES	PATIENT DAYS	154,774	5	349,775	319,993	32,555	73,571	4
5	27	EMPLOYEE BENEFITS	PATIENT DAYS	154,774	5	47,148		32,555	9,917	5
6	24	EDUCATION & SEMINARS	PATIENT DAYS	154,774	5	300		32,555	63	6
7	25	TRANSPORTATION STAFF	PATIENT DAYS	154,774	5	24,038		32,555	5,056	7
8	26	GENERAL INSURANCE	PATIENT DAYS	154,774	5	15,832		32,555	3,330	8
9	30	DEPRECIATION	PATIENT DAYS	154,774	5	20,218		32,555	4,253	9
10	32	INTEREST EXPENSE	PATIENT DAYS	154,774	5	124		32,555	26	10
11	35	EQUIPMENT RENT	PATIENT DAYS	154,774	5	4,066		32,555	855	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 637,674	$ 469,993		$ 134,127	25

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5	RELATED PARTY										26	5
	Working Capital											
6	AMERICAN NATIONAL BANK		X	WORKING CAPITAL	INTEREST	REVOLV	500,000	450,000	REVOLV	PRIME+	27,372	6
7	MEDMARC		X	INSURANCE POLICIES	INTEREST						1,633	7
8												8
9	TOTAL Facility Related						$ 500,000	$ 450,000			$ 29,031	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 500,000	$ 450,000			$ 29,031	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 36,257	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 36,987	2
3. Under or (over) accrual (line 2 minus line 1).		$ 730	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 36,987	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 37,717	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	33,924	8
	1997	35,588	9
	1998	36,603	10
	1999	36,257	11
	2000	36,987	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 100% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ASTA CARE CENTER OF BLOOMINGTON COUNTY MCLEAN

FACILITY IDPH LICENSE NUMBER 0042283

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	41-14-32-427-020 955	NURSING HOME	$ 36,987.30	$ 36,987.30
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 36,987.30	$ 36,987.30

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 0 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$ 0	3

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ROOF & DOORS			1997	8,588	220	39	220		926	9
10	FIRE ALARM CONTROL PANEL			1998	2,880	74	39	74		262	10
11	CHECK VALVES INSTALLATION			1998	3,192	82	39	82		290	11
12	WATER HEATER			1998	5,965	153	39	153		542	12
13	ROOF			1999	14,774	537	27.5	537		1,365	13
14	GARAGE			1999	9,320	339	27.5	339		862	14
15	FENCE			1999	3,510	234	15	234		595	15
16	A/C ROOF UNIT COMPRESSOR			1999	2,314	84	27.5	84		214	16
17	VALVES			2000	1,232	44	27.5	44		68	17
18	BUILT IN CHART RACKS			2000	1,980	72	27.5	72		111	18
19	ROOF			2000	13,310	484	27.5	484		750	19
20	ELECTRICAL WORK			2000	1,600	58	27.5	58		90	20
21	DISPOSAL			2000	1,820	66	27.5	66		102	21
22	ELECTRICAL			2000	1,774	64	27.5	64		99	22
23	WATER LINE			2000	3,100	114	27.5	114		175	23
24	CURTAINS			2000	1,679	411	10	170	(241)	254	24
25	CARPETING			2000	4,599	1,126	10	460	(666)	690	25
26	ELECTRICAL			2001	11,927	235	27.5	235		235	26
27	ROOF TOP UNIT			2001	6,886	136	27.5	136		136	27
28	FLASHING ON ROOF			2001	5,930	117	27.5	117		117	28
29	FENCE			2001	1,722	34	27.5	34		34	29
30	BATHROOM			2001	3,370	66	27.5	66		66	30
31	CARPETING			2001	6,671	1,334	10	334	(1,000)	334	31
32	TILING			2001	8,363	1,673	10	418	(1,255)	418	32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 126,506	$ 7,757		$ 4,595	$ (3,162)	$ 8,735	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 91,721	$ 12,942	$ 9,172	$ (3,770)	10	$ 32,644	71
72	Current Year Purchases	25,197	5,039	1,260	(3,779)	10	1,260	72
73	Fully Depreciated Assets				0			73
74	RELATED PARTY		4,253	4,253	0			74
75	TOTALS	$ 116,918	$ 22,234	$ 14,685	$ (7,549)		$ 33,904	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	ADMIN., ACTIV.	1995 FORD	1997	$ 33,841	$ 3,898	$ 6,769	$ 2,871	5	$ 33,841	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 33,841	$ 3,898	$ 6,769	$ 2,871		$ 33,841	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 277,265	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 33,889	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 26,049	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (7,840)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 76,480	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: BLOOMINGTON PROPERTY LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		117	9/1/96	$ 512,551	30		3
4	Additions							4
5								5
6								6
7	TOTAL		117		$ 512,551 **			7

8. List separately any amortization of lease expense included on page 4, line 34. NONE
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: PURCHASE PRICE 4100000 *

10. Effective dates of current rental agreement:
Beginning 09/01/96
Ending 09/01/26

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2002	$ 527,516
13.	12/31/2003	$ 527,516
14.	12/31/2004	$ 527,516

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 10,415 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$ 71,200	$		$ 71,200	1
2	Licensed Speech and Language Development Therapist		hrs			4,796			4,796	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			123,931			123,931	4
5	Physician Care		visits			617			617	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				100,916		100,916	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Rentals					540			540	13
14	TOTAL			$		$ 201,084	$ 100,916		$ 302,000	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 966	$	1
2	Cash-Patient Deposits	687,632		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	(15,000)		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,176		6
7	Other Prepaid Expenses	2,002		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Real Estate Escrow Deposit	26,101		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 713,877	$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	105,194		15
16	Equipment, at Historical Cost	172,071		16
17	Accumulated Depreciation (book methods)	(115,713)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): COMPUTER SOFTWARE	5,312		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 166,864	$ 0	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 880,741	$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 172,320	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	450,000		29
30	Accrued Salaries Payable	27,319		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,062		31
32	Accrued Real Estate Taxes(Sch.IX-B)	36,987		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Related Parties	246,853		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 939,541	$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	350,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 350,000	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,289,541	$ 0	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (408,800)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 880,741	$ 0	48

***(See instructions.)**

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (166,092)	1
2	Restatements (describe):		2
3			3
4	ROUNDING	(1)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (166,093)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(242,707)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (242,707)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (408,800)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,620,823	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,620,823	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	236,807	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 236,807	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	12	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 12	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	ADJ PRIOR YR EXPENSES	56,068	28
28a	PURCHASES DISC	2,015	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 58,083	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,915,725	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	922,327	31
32	Health Care	1,389,535	32
33	General Administration	860,927	33
	B. Capital Expense		
34	Ownership	619,586	34
	C. Ancillary Expense		
35	Special Cost Centers	302,000	35
36	Provider Participation Fee	64,057	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,158,432	40
41	**Income before Income Taxes (line 30 minus line 40)****	(242,707)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (242,707)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,000	2,190	$ 49,720	$ 22.70	1
2	Assistant Director of Nursing	1,819	2,104	45,124	21.45	2
3	Registered Nurses	13,204	14,219	278,961	19.62	3
4	Licensed Practical Nurses	8,717	9,405	151,597	16.12	4
5	Nurse Aides & Orderlies	35,987	37,753	387,051	10.25	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	2,068	2,227	43,695	19.62	7
8	Rehab/Therapy Aides	4,156	4,360	44,704	10.25	8
9	Activity Director	1,608	1,734	16,847	9.72	9
10	Activity Assistants	3,936	4,135	34,993	8.46	10
11	Social Service Workers	2,582	2,699	41,748	15.47	11
12	Dietician					12
13	Food Service Supervisor	2,735	2,936	31,922	10.87	13
14	Head Cook	4,277	4,591	49,926	10.87	14
15	Cook Helpers/Assistants	16,774	17,535	123,947	7.07	15
16	Dishwashers					16
17	Maintenance Workers	6,227	6,828	75,360	11.04	17
18	Housekeepers	20,350	21,712	152,351	7.02	18
19	Laundry	6,689	7,137	50,433	7.07	19
20	Administrator	2,013	2,136	101,592	47.56	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,295	7,877	97,044	12.32	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) clerical nursing	2,183	2,361	27,787	11.77	33
34	TOTAL (lines 1 - 33)	144,620	153,939	$ 1,804,802 *	$ 11.72	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 6,111	1-3	35
36	Medical Director	O	6,000	9-3	36
37	Medical Records Consultant	N	1,500	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	550	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	1,536	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify) Psycho Social	S	2,952	10-3	46
47	Program Consultant		1,360	10-3	47
48	Dental Consultant		92	10-3	48
49	TOTAL (lines 35 - 48)		$ 20,101		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	783	$ 31,171	10-3	50
51	Licensed Practical Nurses	2,057	66,685	10-3	51
52	Nurse Aides	3,404	84,664	10-3	52
53	TOTAL (lines 50 - 52)	6,244	$ 182,520		53

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
NANCY HARTMAN	ADMIN	0	$ 101,592
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 101,592

B. Administrative - Other

Description	Amount
ASTA HEALTHCARE CO., INC - MNMNT FEES	$ 132,500
TOTAL (agree to Schedule V, line 17, col. 3)	$ 132,500
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		42,292
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 42,292

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 33,374
Unemployment Compensation Insurance	13,178
FICA Taxes	132,823
Employee Health Insurance	60,304
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	5,418
EMPLOYEE PHYSICAL EXAMS	7,706
PENSION/PROFIT SHARING PLANS	7,517
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 260,320

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	6,495
Health Care Worker Background Check	1,013
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	50,183
RELATED PARTY	321
CONTRIBUTIONS	5,846
DUES & SUBSCRIPTIONS	8,145
LICENSES & PERMITS	7,460
TRUST FEES/FRANCHISE TX/ETC	(5,846)
Less: Public Relations Expense	(0)
Non-allowable advertising	(50,183)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,434

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	181
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 181

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATING	1998	$ 9,240	3	$ 1,540	$ 3,080	$ 3,080	$ 1,540	$	$	$	$	$
2	PAINT/DECORATING	1999	3,409	3		568	1,136	1,136	569				
3	PAINT/DECORATING	2000	15,888	3			2,648	5,296	5,296	2,648			
4	PAINT/DECORATING	2001	14,724	3				2,454	4,908	4,908	2,454		
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 43,261		$ 1,540	$ 3,648	$ 6,864	$ 10,426	$ 10,773	$ 7,556	$ 2,454	$	$

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON # 0042283 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL HEALTH CARE ASSOC. $6230**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **NONE** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES **X** NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
CARE CENTRE OF BLOOMINGTON LLC #0000410979 9/1/96

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **64,057**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: ASTA CARE CENTER OF BLOOMINGTON #0042283 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	6,111	
	REPAIRS & MAINTENANCE		5,562	
			0	11,673
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		1,270	
	LINEN REPLACEMENT		7,553	8,823
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		20,419	
	ELECTRICITY		73,173	
	WATER		44,379	
	CABLE TV - LOBBY		4,862	
			0	142,833
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		12,955	
	PAINTING & DECORATING		14,724	
	BUILDING REPAIRS		2,039	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		11,254	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		1,919	
	FIRE SERVICE		5,471	
			0	
			0	
			0	48,362
7	**OTHER**			
	SCAVENGER		29,243	
	SECURITY SERVICE		0	29,243
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	6,000	6,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	182,520	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	2,952	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,500	
	PHARMACY CONSULTANT	XVIII B 39-2	550	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	PROGRAM CONSULTANT		1,360	
	DENTAL		3,250	192,132
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,536	
			0	1,536
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number ASTA CARE CENTER OF BLOOMINGTON #0042283 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	132,500	132,500
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	7,018	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	35,274	
			0	42,292
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	50,183	
	EMPLOYEE WANT ADS	XIX F	6,495	
	CONTRIBUTIONS	VI 20 XIX F	5,846	
	DUES & SUBSCRIPTIONS	XIX F	8,145	
	LICENSES & PERMITS	XIX F	7,460	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,013	79,142
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES		1,297	
	EQUIPMENT REPAIR & MAINTENANCE		386	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	8,515	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		1,401	
	TELEPHONE		30,165	
	MESSENGER SERVICE		544	
			0	42,308

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	132,823	
	UNEMPLOYMENT COMPENSATION	XIX D	13,178	
	WORKERS COMPENSATION INSURANC	XIX D	33,374	
	HOSPITALIZATION INSURANCE	XIX D	60,304	
	EMPLOYEE BENEFITS - OTHER	XIX D	5,418	
	EMPLOYEE PHYSICAL EXAMS	XIX D	7,706	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	7,517	
	CHICAGO HEAD TAX	XIX D	0	260,320
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		5,875	5,875
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	181	
			0	
			0	181
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		6,181	6,181
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		50,081	50,081
27	**OTHER**			
	BAD DEBTS	VI 24	14,574	
			0	14,574

GRAND TOTAL COLUMN 3 OTHER 1,074,056

ASTA CARE CENTER OF BLOOMINGTON
EMPLOYEE MEAL RECLASSIFICATION
12/31/2001

TOTAL FOOD PURCHASE	123,546	PATIENT MEALS	97665
LESS SALES TAX	(1,782)	ADD EMPLOYEE MEALS	0
NET FOOD	125328	TOTAL MEALS/YEAR	97665
TOTAL PATIENT CENSUS	32,555	NET FOOD	125328
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	97665
TOTAL PATIENT MEALS	97665	COST PER MEAL	1.28
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		